

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11031

FILED APR 22 1940

Registration District No. 218

Primary Registration District No. 5440

Registrar's No. 242

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
MEDICAL CENTER FOR FEDERAL PRISONERS
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days
(Specify whether
In this community 6 days
years, months or days)

3. (a) PRINT FULL NAME CRIFE, Carl Edwin

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased February 1, 1890
(Month) (Day) (Year)

8. AGE: Years 50 Months 1 Days 5 If less than one day
hr. _____ min. _____

9. Birthplace Upham N. Dakota
(City, town, or county) (State or foreign country)

10. Usual occupation Barber

11. Industry or business Barber Shop

12. Name: Henry Owen Crife,

13. Birthplace Unknown Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Ella Steers,

15. Birthplace Unknown Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Deceased.

(b) Address _____

17. (a) _____ (b) Date thereof 3/9/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Eastlawn Cem.

18. (a) Signature of funeral director Theime Funeral Home,

(b) Address Springfield, Missouri

19. (a) 3/9/40 (b) Chas. J. George
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MONTANA (b) County _____
(c) City or town Deer Lodge
(If outside city or town limits, write "RURAL")
(d) Street No. Unknown
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 6
year 1940 hour 3:00 minute 55 P. M.

21. I hereby certify that I attended the deceased from March 1,
1940, 19____, to March 6, 1940, 19____;
that I last saw him alive on March 6, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Endocarditis, chronic
mitral valve
Duration
about
1 yr.

Due to _____

Due to _____

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy Yes, confirmed previous
diagnosis.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? No (Specify type of place)
(e) Means of injury Surgery

23. Signature E. W. Green, USPHS (M. D. or other) _____

Address Clinical Director MCFP. Date signed 3-7-40

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision. .

Signed..... *R. H. Williams*

Licensed Embalmer No. *3681*

P. O. Address..... *Springfield, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.